Renown™
INSTITUTE FOR HEART & VASCULAR HEALTH

Patient Medical History

Name: ____ MRN: ______________________

Date of Visit: ______________________________ Primary Care Provider: ____________________________

Date of Birth: _____________________________ Age: ______ Reason for Visit: ____________________

Referring physician: ________________________

Personal Medical History

1. **Coronary artery disease** ☐Yes ☐No
   Heart attack? When: ______________
   Bypass surgery? When: ______________
2. **Heart valve disease** ☐Yes ☐No
3. **Heart failure** ☐Yes ☐No
4. **High blood pressure** ☐Yes ☐No
5. **High cholesterol** ☐Yes ☐No
6. **Peripheral Vascular Disease** ☐Yes ☐No
7. **Heart Murmur** ☐Yes ☐No
8. **Rapid or irregular heart beat** ☐Yes ☐No
9. **Dizziness/ lightheadedness** ☐Yes ☐No
10. **Blood vessel Surgery** ☐Yes ☐No
    When? _____________
11. **Rheumatic fever as a child** ☐Yes ☐No
12. **Chest pain** ☐Yes ☐No
13. **Swollen Legs** ☐Yes ☐No
14. **Leg cramps while walking** ☐Yes ☐No
15. **Stroke** ☐Yes ☐No When? ____________
16. **Diabetes** ☐Yes ☐No How long? __________
17. **Surgeries**____________________________
    ____
    ____
18. **Hospitalizations** ______________________
    ____

Family Medical History

Has anyone in your family had:

1. **Coronary artery disease** ☐Yes ☐No Relationship: ______________ Age at time of event: _______
2. **Heart attack** ☐Yes ☐No Relationship: ______________ Age at time of event: _______
3. **Bypass surgery** ☐Yes ☐No Relationship: ______________ Age at time of event: _______
4. **Died suddenly** ☐Yes ☐No Relationship: ______________ Age at time of event: _______
5. **Heart murmur** ☐Yes ☐No Relationship: ______________ Age at time of event: _______
6. **Hypertension** ☐Yes ☐No Relationship: ______________ Age at time of event: _______

Social History/ Personal Habits

1. **Do you smoke?** ☐Yes ☐No Number per day? __________ For how many years? ________
2. **Do you drink alcohol?** ☐Yes ☐No Amount per day? __________ For how many years? ________
3. **Do you drink caffeine?** ☐Yes ☐No Amount per day? __________ For how many years? ________
4. **Do you use recreational drugs?** ☐Yes ☐No Amount per day? __________ For how many years? ________
5. **Do you exercise?** ☐Yes ☐No Amount per day? __________ For how many years? ________
6. **Occupation:** ____
7. **Marital status:** ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Partnered
8. **Children:** ☐Yes ☐No

Allergies

________________________________ ________________________________

________________________________ ________________________________

Organ Systems Review

Constitutional:

- ☐ Fever
- ☐ Chills
- ☐ Weight Loss
- ☐ Malaise / Fatigue
- ☐ Diaphoresis
- ☐ Weakness

Skin:

- ☐ Rash
- ☐ Itching

HENT:

- ☐ Headaches
- ☐ Hearing loss
- ☐ Tinnitus
- ☐ Ear pain
- ☐ Ear discharge
- ☐ Nose bleeds
- ☐ Congestion
- ☐ Stridor
- ☐ Sore throat

Eyes:

- ☐ Blurred vision
- ☐ Double vision
- ☐ Photophobia
- ☐ Eye pain
- ☐ Eye discharge
- ☐ Eye redness

Cardiovascular:

- ☐ Chest pain
- ☐ Palpitations
- ☐ Orthopnea
- ☐ Claudication
- ☐ Leg swelling
- ☐ PND

Respiratory:

- ☐ Cough
- ☐ Hemoptysis
- ☐ Sputum production
- ☐ Shortness of breath
- ☐ Wheezing

Gastrointestinal:

- ☐ Heartburn
- ☐ Nausea
- ☐ Vomiting
- ☐ Abdominal pain
- ☐ Diarrhea
- ☐ Constipation
- ☐ Blood in stool
- ☐ Melena

Genitourinary:

- ☐ Dysuria
- ☐ Urgency
- ☐ Frequency
- ☐ Hemaluria
- ☐ Flank pain

Musculoskeletal:

- ☐ Myalgias
- ☐ Neck pain
- ☐ Back pain
- ☐ Joint pain
- ☐ Falls

Endo/Heme/Aller:

- ☐ Easy bruise/bleed
- ☐ Env allergies
- ☐ Polydipsia

Neurological:

- ☐ Dizziness
- ☐ Tingling
- ☐ Tremor
- ☐ Sensory change
- ☐ Speech change
- ☐ Focal weakness
- ☐ Seizures
- ☐ LDC

Psychiatric:

- ☐ Depression
- ☐ Suicidal ideas
- ☐ Substance abuse
- ☐ Hallucinations
- ☐ Nervous / Anxious
- ☐ Insomnia
- ☐ Memory loss